# SUPPLEMENTAL MEDICAID SCHEDULE KMAP-4



## DISPROPORTIONATE SHARE HOSPITAL QUESTIONNAIRE

**FACILITY:** _____ **FYE:** _____

**VENDOR NUMBER:** _____

1a. Did your facility offer nonemergency obstetric services as of December 21, 1987? (ANSWER YES "ONLY" IF THERE WERE "AT LEAST" 2-OB'S OR PHYSICIANS WHO OFFERED NON-EMERGENCY OBSTETRIC SERVICES.)
**Yes** _____
**No** _____

b. Does your facility predominantly serve individuals under 18 years of age?
**Yes** _____
**No** _____
If yes, indicate the percent of the individuals under 18 years of age.
**%** 0.0%

c. Does your facility have at least two obstetricians with staff privileges who have agreed to provide obstetric services to Medicaid eligible individuals? In the case of a hospital located in a rural area (that is an area outside a Metropolitan Statistical Area), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.
**Yes** _____
**No** _____

2. Enter the total Medicaid inpatient revenues (payments) paid to your facility, plus the amount of cash subsidies received directly from state and local governments.
**$** 0

3. Enter the total inpatient revenues (payments) paid to your facility, plus the amount of cash subsidies received directly from state and local governments.
**$** 0

4. Enter the total amount of the facility's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources).

The total inpatient charges attributed to charity care should not include bad debts or contractual allowances and discounts (other than for indigent patients not eligible for Medicaid), that is, reductions in charges given to other third party payers, such as HMOs, Medicare or Blue Cross.

The charges should be net of any cash subsidies for patient services received directly from state and local governments in the period attributable to inpatient hospital services.
**$** 0

5. Enter the total amount of the facility's charges for inpatient services.
**$** 0

The above statements are accurate and correct to the best of my knowledge.

Signed: _____
President, Administrator, or Chief Financial Officer

# SUPPLEMENTAL MEDICAID SCHEDULE KMAP-1

## Computation of Legal Fees, Political Contributions, and Out-of-State travel not Allowable to KMAP

| | | | |
|---|---|---|---|
| **1. Legal Fees** | 0 | | |
| **2. Political** | | **HOSPITAL** | **0** |
| **Contributions** | 0 | **VENDOR NO** | **0** |
| **3. Out-of-State Travel** | 0 | **PERIOD FROM** | |
| **4. HICAP ASSESSMENT** | | | |
| **5. Total Non-Allowable Cost** | 0 | **PERIOD TO** | |

| | Column 1 | Column 2 | Column 3 | Column 4 |
|---|---|---|---|---|
| | COST CENTERS | From Medicare Cost report Worksheet B Part 1 | Accumulated Costs | Allocated Non-Allowable Costs |
| 6. | Inpatient routine Service<br>A. Hospital | Total of Lns.<br>25-30 & 33 | 0 | 0 |
| | B. Sub Providers<br>(other than Inpatient Hospital) | Lns. 31, 32,<br>34-36 | 0 | 0 |
| 7. | Ancillary Service Cost Center | Total of Lines<br>37-59 | 0 | 0 |
| 8. | Outpatient Service Cost Centers | Tot Lns. 60-63 | 0 | 0 |
| 9. | Home Program Dialysis | Ln. 64 | | 0 |
| 10. | Ambulance Services | Ln. 65 | | 0 |
| 11A. | Intern-Res. Srvc. Not Appr. (I/P) D-2, Ln. 19, Col. 2* | Ln. 70 | 0 | 0 |
| 11B. | Intern-Res. Srvc. Not Appr. (O/P) D-2, Line 24, Col. 2* | | 0 | 0 |
| 12. | Other Cost Centers | Ln. 71-94 | 0 | 0 |
| 13. | Non-Reimbursable Cost Centers | Tot. Lns. 96-103 | 0 | 0 |
| 14. | Total Expenses (Sum of Lns. 6-13) | | 0 | 0 |
| 15. | Total Non-Allowable Costs (Line 5) | | 0 | |
| 16. | Unit Cost Multiplier (Ln. 15 / Ln. 14) | | 0.00000000 | |
| 17. | Non-Allowable Cost Applicable to Inpt. Costs | | | 0 |
| 18. | Medicaid Inpatient Allowable Cost (Supplemental Worksheet E-3, Part III. Total of Lns. 1 thru 6, excluding all outpt.) divided by the total Inpt. allowable hospital cost (Worksheet B, Part I) See Instructions Attached | 0<br>0 | | 0.000000 |
| 19. | Medicaid Non-Allowable Cost Line 17 X Line 18 | | | 0 |
| 20. | Medicaid Allowable Cost. Deduct the amount entered on Line 18 from the Title XIX Inpatient Cost on E-3 Part III, Col 1, Line 6 | | | 0 |
| | **OUTPATIENT** | | | |
| 21. | Non-Allowable cost applicable to outpatient cost from line 8 and 11B. | | | 0 |
| 22. | Determination of Medicaid Non-allowable Cost. (See Instructions Attached) | 0<br>0 | | 0.000000 |
| 23. | Medicaid Non-Allowable Outpatient Cost. (Line 21 X Line 22) | | | 0 |
| 24. | Medicaid Allowable Outpatient Cost. Deduct the amount entered on Line 23 from the Title XIX Outpatient Cost on E-3 Part III Col 2 Line 6 | | | 0 |

* Costs are broken between Inpatient and Outpatient Departments on W/sheet D-2